

**Memorandum**

Date MAY 2 2000  
From *for* Michael Mangano  
June Gibbs Brown  
Inspector General

Subject Review of Outpatient Psychiatric Services Provided by the Danbury Hospital for Fiscal Year Ending September 30, 1997 (A-01-99-00518)

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

This memorandum is to alert you to the issuance on Thursday, May 4, 2000, of our final report entitled, "Review of Outpatient Psychiatric Services Provided by the Danbury Hospital for Fiscal Year Ending September 30, 1997." A copy of the report is attached. The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. We found that the Danbury Hospital (Hospital), located in Danbury, Connecticut, did not establish or follow existing procedures for the proper billing of outpatient psychiatric services. We believe our audit findings are significant in that over \$750,000 of the almost \$1.3 million of submitted charges from the Hospital, as outlined below, did not meet Medicare's reimbursement criteria.

This audit of hospital outpatient claims was conducted in conjunction with our 10-State review of outpatient psychiatric services at acute care hospitals, in which our office found significant error rates regarding provider compliance with Medicare requirements. Additional audits of hospital specific outpatient psychiatric services are in process and our results will be reported to you upon completion of each audit.

Our audit at the Hospital determined that a significant amount of the outpatient psychiatric charges submitted by the Hospital did not meet the Medicare criteria for reimbursement. Specifically, we identified charges for psychiatric services not certified by a physician in accordance with Medicare requirements, not properly supported by medical records, or not covered under Medicare. Based on a statistical sample, we estimate that at least \$750,790 in outpatient psychiatric charges submitted by the Hospital did not meet Medicare criteria for reimbursement. We also identified \$126,480 in costs ineligible for Medicare reimbursement claimed by the Hospital on its Fiscal Year (FY) 1997 cost report for outpatient psychiatric services.

We recommended that the Hospital strengthen its procedures to ensure that charges for psychiatric services are covered and properly documented in accordance with Medicare requirements. We also recommended that the Hospital establish nonreimbursable cost centers or otherwise exclude costs related to non-covered services from its Medicare cost

reports. We will provide the results of our review to the fiscal intermediary (FI) so that it can apply the appropriate adjustments of \$750,790 and \$126,480 to the Hospital's FY 1997 Medicare cost report.

The Hospital, in its February 22, 2000 response to our draft report, acknowledged that it needs to improve its documentation standards and has taken steps to provide training to staff and to monitor compliance through various internal initiatives. However, in regard to our finding of \$750,790 in estimated overpayments, the Hospital expressed general concerns regarding the criteria applied during the audit and stated that the Office of Inspector General unfairly applied the medical review standards of the new FI which was not under contract in Connecticut during the audit period. The Hospital also specifically disputed portions of this finding by stating that (1) partial hospitalization program services denied for lack of physician certification were indeed proper, and (2) services denied for being recreational and diversionary in nature were appropriate for patient treatment.

In regard to our identification of \$126,480 in unallowable outpatient psychiatric costs claimed on its FY 1997 cost report, the Hospital was in agreement with \$88,850 of these costs as they were also identified in the Hospital's concurrent internal review. However, the Hospital disagreed with the remaining costs we found unallowable, but stated that it was unable to provide validating documentation to support its contention.

We believe that our final audit determinations are correct and in accordance with Medicare requirements. The basis for our position is discussed in detail beginning on page 9 of the attached report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or William J. Hornby, Regional Inspector General for Audit Services, Region I, (617) 565-2689.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF OUTPATIENT  
PSYCHIATRIC SERVICES PROVIDED  
BY THE DANBURY HOSPITAL FOR  
FISCAL YEAR ENDING  
SEPTEMBER 30, 1997**



**JUNE GIBBS BROWN  
Inspector General**

**MAY 2000  
A-01-99-00518**



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203  
(617) 565-2684

CIN A-01-99-00518

Mr. Frank Kelly  
President  
Danbury Hospital  
24 Hospital Avenue  
Danbury, Connecticut 06810

Dear Mr. Kelly:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Outpatient Psychiatric Services Provided by the Danbury Hospital for Fiscal Year Ending September 30, 1997." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5)

To facilitate identification, please refer to Common Identification Number A-01-99-00518 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in cursive script that reads "William J. Hornby".

William J. Hornby  
Regional Inspector General  
for Audit Services

Enclosures

Page 2 - Mr. Frank Kelly

**Direct Reply to HHS Action Official:**

Ms. Judith Berek  
Regional Administrator  
Health Care Financing Administration  
26 Federal Plaza Room 3811  
New York, New York 10278-0063

## **EXECUTIVE SUMMARY**

### **Background**

The Medicare program reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. Medicare requirements define outpatient services as "Each examination, consultation or treatment received by an outpatient in any service department of a hospital...." Medicare further requires that charges reflect reasonable costs, and services provided be supported by medical records. These records must contain sufficient documentation to justify the treatment provided. Hospital costs for such services are generally facility costs for providing the services of staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year end, the hospital submits a cost report to the Medicare fiscal intermediary (FI) for final reimbursement.

### **Objective**

The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements.

### **Summary of Findings**

For its Fiscal Year (FY) ending September 30, 1997, the Danbury Hospital (Hospital) submitted for reimbursement \$1,271,322 in charges for outpatient psychiatric services. To determine whether controls were in place to ensure compliance with Medicare requirements, we reviewed the medical and billing records for 100 randomly selected claims totaling \$38,440. These services were charged on behalf of patients in the Hospital's partial hospitalization program (PHP) and other outpatient psychiatric programs. Our analysis showed that \$31,152 of these charges did not meet Medicare criteria for reimbursement. Specifically, we found:

- ◇ \$20,354 in charges for PHP services not certified by a physician in accordance with Medicare requirements, and
- ◇ \$10,798 in other outpatient psychiatric charges for services insufficiently documented or not covered under Medicare.

We extrapolated these results to the population of Medicare claims from the Hospital during FY 1997 and estimated that the Hospital overstated its billings to Medicare by \$750,790. Accordingly, we found that the Hospital did not either establish or follow existing procedures for the proper billing of outpatient psychiatric services.

Medicare requires costs claimed to the program be reasonable, allowable, allocable, and related to patient care. We reviewed selected Hospital expense accounts pertaining to outpatient

psychiatric services and found \$126,480 in costs claimed on the Hospital's FY 1997 Medicare cost report to be ineligible for Medicare reimbursement. These included costs for patient transportation, patient meals, and unallowable advertising.

## **Recommendations**

We recommended that the Hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. We also recommended that the Hospital develop procedures to establish nonreimbursable cost centers or to otherwise exclude costs related to noncovered services from its FY 1997 Medicare cost report.

We will provide the FI with details of the \$750,790 in estimated overpayments for outpatient psychiatric services and the \$126,480 in unallowable costs, so that it can apply the appropriate adjustment to the Hospital's FY 1997 Medicare cost report.

The Hospital, in its February 22, 2000 response to our draft report (see APPENDIX B), acknowledged that it needs to improve its documentation standards and has taken steps to provide training to staff and to monitor compliance through various internal initiatives. We commend the Hospital for these actions. However, in regard to our finding of \$750,790 in estimated overpayments, the Hospital expressed general concerns regarding the criteria applied during the audit and stated that the Office of Inspector General (OIG) unfairly applied the medical review standards of the new FI which was not under contract in Connecticut during the audit period. The Hospital also specifically disputed portions of this finding by stating that (1) PHP services denied for lack of physician certification were indeed proper, and (2) services denied for being recreational and diversionary in nature were appropriate for patient treatment.

In regard to our identification of \$126,480 in unallowable outpatient psychiatric costs claimed on its FY 1997 cost report, the Hospital was in agreement with \$88,850 of these costs as they were also identified in the Hospital's concurrent internal review. However, the Hospital disagreed with the remaining costs we found unallowable but stated that it was unable to provide validating documentation to support its contention.

We believe that our final audit determinations are correct and no further adjustments to our report are necessary. The basis for our position is discussed beginning on page 9 of this report.

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## INTRODUCTION

### BACKGROUND

The Medicare program established by Title XVIII of the Social Security Act (Act) provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Health Care Financing Administration (HCFA). Under section 1862 (a)(1)(A), the Act excludes coverage for services, including outpatient psychiatric services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Outpatient psychiatric services are generally provided by hospital employees such as staff psychiatrists, psychologists, clinical nurse specialists, and clinical social workers. Claims are submitted for services rendered and are reimbursed on an interim basis based on submitted charges. At year end, the hospital submits a cost report to the Medicare FI for final reimbursement. Medicare requires that for benefits to be paid:

- ◇ “A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.” [42 CFR §482.24]
- ◇ Psychiatric “...services must be...reasonable and necessary for the diagnosis or treatment of a patient’s condition...Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.” [Medicare Intermediary Manual §3112.7]
- ◇ Psychosocial programs are defined as “...community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. Partial hospitalization programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they would be covered. However, if an individual’s outpatient hospital program consists entirely of psychosocial activities....” such services would not be covered. [Medicare Intermediary Manual §3112.7]

In addition, for an individual's PHP to be covered,

- ◇ a physician must certify that "...the individual would require inpatient psychiatric care in the absence of such services...." [Social Security Act §1835(a)(2)(F)]
- ◇ a physician must certify that "The individual would require inpatient psychiatric care if the partial hospitalization services were not provided." [42 CFR §424.24]
- ◇ "This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted." [HCFA Program Memorandum, Publication 60A]

For costs claimed on a hospital's Medicare cost report, Medicare requirements define:

- ◇ reasonable costs as "...all necessary and proper expenses incurred in furnishing services...However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable...." [42 CFR §413.9(c)(3)]
- ◇ noncovered outpatient psychiatric services to include patient meals and patient transportation. It also limits drug coverage only to those which cannot be self-administered. [Medicare Intermediary Manual §3112.7]
- ◇ "Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable...." [Provider Reimbursement Manual §2136.2]

The Hospital, a 241 bed acute care facility in Danbury, Connecticut, provides outpatient psychiatric services to patients in the greater Danbury area. The Hospital provides these services through its PHPs and through other outpatient psychiatric programs. For FY 1997, the Hospital submitted for Medicare reimbursement 4,916 claims for outpatient psychiatric services valued at \$1,271,322.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

The objective of our review was to determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicare requirements. Our review included services provided and costs incurred during FY 1997.

We conducted our audit during May and June of 1999 at the Hospital in Danbury, Connecticut in accordance with generally accepted government auditing standards.

We limited consideration of the internal control structure to those controls concerning claims submission because the objective of our review did not require an understanding or assessment of the complete internal control structure at the Hospital.

To accomplish our objective, we:

- ◇ reviewed criteria related to outpatient psychiatric services;
- ◇ obtained an understanding of the Hospital's internal controls over Medicare claims submission;
- ◇ used the Provider Statistical and Reimbursement Report provided by the FI for the Hospital's FY 1997 to identify 4,916 outpatient psychiatric claims submitted by the Hospital valued at \$1,271,322. Such claims were identified by revenue center codes 513 (psychiatric clinic), and 900-904, 909-912 and 914-919 (psychiatric/psychological services).
- ◇ employed a stratified random sample approach to select a statistical sample of 100 outpatient psychiatric claims. Stratum 1 consisted of 60 claims from the 513 revenue center code and Stratum 2 consisted of 40 claims from the aforementioned revenue center codes in the 900 series;
- ◇ performed detailed audit testing on the billing and medical records for the claims selected in the sample;
- ◇ utilized medical review staff from Empire Medicare Services, the Medicare FI, and psychiatrists from Qualidigm, the Connecticut peer review organization (PRO), to review each of the 100 outpatient psychiatric claims;
- ◇ used a variable appraisal program to estimate the dollar impact of improper payments in the total population; and

In addition, the Hospital allocated to the Medicare program about \$1.7 million in outpatient psychiatric costs, after reclassifications and adjustments, on its FY 1997 Medicare cost report. We tested the allowability of these costs through examination of several Hospital expense accounts pertaining to nonsalary expenses.

The Hospital's response to the draft report is appended to this report (see APPENDIX B). The Hospital also provided us, under separate cover, a detailed case-by-case response to our findings during our January 11, 2000 exit conference. For reasons of patient confidentiality, we have not appended this detailed response to our report. However, we have addressed the Hospital's aggregate response beginning on page 9.

## **FINDINGS AND RECOMMENDATIONS**

The Hospital provides outpatient psychiatric services under several programs in the greater Danbury, Connecticut area. Many of the services provided to Medicare beneficiaries are provided through the Hospital's Community Center for Behavioral Health (CCBH), Responsive Services Program (RSP), and Crisis Intervention Program (CIP). Within these programs, the Hospital provides PHP care as well as other outpatient psychiatric services.

In FY 1997, the Hospital submitted for Medicare reimbursement \$1,271,322 in charges for outpatient psychiatric services. We reviewed the medical and billing records for 100 statistically selected claims comprising 379 individual services totaling \$38,440 in charges. Our analysis disclosed that \$31,152 of the sampled charges did not meet Medicare criteria for reimbursement. Based on a statistical sample, we estimate that the Hospital had overstated its FY 1997 Medicare outpatient psychiatric charges by at least \$750,790. Charges found unallowable were for services which lacked physician certification, proper medical record documentation, or were not covered by the Medicare program.

The Hospital claimed about \$1.7 million in costs for providing these outpatient psychiatric services, after reclassifications and adjustments, on its FY 1997 Medicare cost report. We reviewed several judgmentally selected nonsalary expense accounts and found \$126,480 in costs were unallowable under Medicare requirements. These included unallowable costs for patient meals, patient transportation, and promotional advertising costs.

Findings from our review of medical records and outpatient psychiatric costs are described in detail below.

### **MEDICAL RECORD REVIEW**

#### **PARTIAL HOSPITALIZATION PROGRAM**

The PHP services are provided to Medicare beneficiaries through the Hospital's CCBH. The Hospital describes this program as "...a multi-disciplinary treatment program providing comprehensive assessment, treatment, support, and education for adults seeking to recover from the effects of psychiatric illness...." From our sample of 100 outpatient psychiatric claims, 19 of these claims<sup>1</sup>, representing 142 services and totaling \$20,354 in charges, were for services provided to PHP patients. Our review, however, showed that these services did not meet Medicare criteria for reimbursement because they lacked the proper physician certification required by Medicare.

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<sup>1</sup>These claims were from Stratum 2 which consisted of 40 outpatient psychiatric claims from the 900 revenue center code series. The remaining 21 claims in this stratum were for other outpatient psychiatric services.

### ***Services Not Certified by a Physician***

Under 42 CFR §424.24, in order for an individual's PHP to be covered, a physician must certify that "The individual would require inpatient psychiatric care if the partial hospitalization services were not provided." Further, HCFA Program Memorandum, Publication 60A states that, "This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted."

We found that the Hospital did not have procedures in place for physicians to certify that patients placed into the intense treatment of a PHP would require inpatient psychiatric care in lieu of such services. From our review of the billing and medical records for the 19 PHP claims, we identified \$20,354 in charges for 142 PHP services billed to the Medicare program which were not certified by a physician.

Specifically, we found cases for which a patient was receiving the intense level of care from the PHP but for whom a physician had not certified that the patient would require inpatient psychiatric care in lieu of such services.

In addition to identifying the lack of physician certification for these services, medical reviewers also noted other deficiencies with many of these services, including the lack of individual notes for each service billed and the lack of complete treatment plans for these patients. Without such medical record documentation, these claims would not meet Medicare criteria for reimbursement.

### **OTHER OUTPATIENT PSYCHIATRIC SERVICES**

In addition to its PHP, the Hospital provides other outpatient psychiatric services. These services were provided through the Hospital's CCBH, CIP, and RSP. Services from these programs include individual and group psychotherapy sessions, physician medication reviews, and emergency crisis treatment. Our sample of 100 claims contained 81 such claims for 237 services valued at \$18,086<sup>2</sup>. We found that 31 claims, representing 162 services valued at \$10,798, did not meet Medicare criteria for reimbursement as detailed below.

### ***Incomplete Patient Treatment Plans***

The Medicare Intermediary Manual, section 3112.7(B) states that for outpatient hospital psychiatric services to be covered, "Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals...."

Section 3112.7 continues by stating, "Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation

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<sup>2</sup>These 81 claims consisted of 60 claims from Stratum 1 and 21 claims from Stratum 2.

must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also...determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.”

We found that the Hospital did not have adequate procedures in place for preparing complete individualized treatment plans for each patient receiving ongoing psychiatric care. From our review of the billing and medical records for the 81 other outpatient psychiatric claims in our sample, we identified \$5,351 in charges for 82 services to patients whose treatment plans did not comply with Medicare requirements or which were otherwise missing. With the assistance of medical review personnel from the FI and PRO, we identified:

- ◇ \$4,538 in charges for 69 services to patients whose treatment plans were missing essential elements including type, amount, frequency, and duration of services to be provided,
- ◇ \$638 in charges for 10 services to patients who did not have an individualized written treatment plan, and
- ◇ \$175 in charges for three services to a patient whose treatment plan showed no evidence that it was prescribed by a physician, as it was not signed by a physician.

### ***Services Not Covered by the Medicare Program***

The Act, §1862(a)(1)(A) states that no payment shall be made for any services which “...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” With regard to outpatient psychiatric services, the Medicare Intermediary Manual, section 3112.7 identifies a wide range of services a hospital may provide to outpatients in need of psychiatric care. Identified under this section are psychosocial programs, defined as “...community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. Partial hospitalization programs may include some psychsocial components; and to the extent these components are not primarily for social or recreational purposes, they would be covered. However, if an individual’s outpatient hospital program consists entirely of psychosocial activities....” such services would not be covered.

We found that the Hospital did not have adequate procedures in place for ensuring that only covered services are billed to the Medicare program. With the assistance of medical reviewers from the Connecticut FI and PRO, we reviewed 81 outpatient psychiatric claims and identified \$5,114 in charges for 74 noncovered services. In this regard, medical reviewers determined through review of the patients’ progress notes and treatment plans that the patients’ care consisted primarily of psychosocial encounters and, therefore, such services were not allowable under the Medicare program. These services pertained to patients in the Hospital’s RSP. Many of these services, billed as an “RSP Brief Visit”, were documented to show the patient coming into the clinic to be dispensed a self-administered medication and receiving an allotment of money from his custodial bank account. Some progress notes documented a discussion of the

patient's financial and housing arrangements. In claims for a "RSP Full Visit" the patient would generally receive the above services and then be taken on a shopping trip to a local supermarket. We also found claims for bowling and dinner socialization groups for patients in this program.

### ***Services Not Supported by Medical Records***

The 42 CFR §482.24 states that, "A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."

Our audit disclosed a weakness in the Hospital's system of internal controls regarding medical record documentation supporting its Medicare charges. Our review of the 81 outpatient psychiatric claims disclosed \$333 in charges representing 6 services for which Hospital staff were unable to locate a corresponding progress note in the patient's chart.

### **REVIEW OF OUTPATIENT PSYCHIATRIC COSTS**

The Hospital claimed approximately \$1.7 million in costs for providing outpatient psychiatric services, after reclassification and adjustments, on its FY 1997 Medicare cost report. From this amount, we tested selected nonsalary expense accounts. Our analysis showed that \$126,480 in outpatient costs reviewed were unallowable.

Medicare Intermediary Manual, §3112.7 identifies noncovered outpatient psychiatric services to include meals and transportation. The Provider Reimbursement Manual, §2136.2 states that, "Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable...."

We found that the Hospital did not have adequate procedures in place to establish nonreimbursable cost centers or to otherwise exclude costs related to noncovered services from its FY 1997 Medicare cost report.

We found during our review that the Hospital maintains expense accounts to record costs incurred for patient travel, patient meals, and advertising. These accounts are titled "client travel," "nourishment expense," and "advertising", respectively and are maintained for each of the Hospital's outpatient psychiatric programs. We tested costs within these accounts and concluded that expenses posted to these accounts are not allowable for Medicare reimbursement. Specifically, we identified:

- ◇ \$41,414 for patient meal costs, including catering costs for meals and snacks, provided to PHP patients, and grocery and fast food items provided to patients in other outpatient psychiatric programs;
- ◇ \$67,972 for patient transportation costs, including transportation of patients to their therapy sessions, and Hospital employee travel reimbursement for private

vehicle travel to and from State facilities to pick up State cars used in providing patient transportation. Also included are costs for leasing vehicles used for patient transportation and the upkeep costs for these vehicles; and

- ◇ \$17,094 for unallowable advertising costs made to local newspapers, publishers, and printing companies. These unallowable costs consisted mainly of newspaper advertisements promoting the Hospital's psychiatric programs.

As a result, we believe that the Hospital overstated its FY 1997 Medicare cost report by \$126,480. During the course of our audit, the Hospital submitted a letter to the FI, dated May 25, 1999, stating that based on our initial inquiry, the Hospital had conducted an internal review and had identified \$88,850 in potential disallowances. We confirmed the Hospital's disclosure and have incorporated its findings into this report. We commend the Hospital for taking a proactive approach in self-disclosing these conditions to the FI.

In addition to the above unallowable costs identified by the Hospital in its letter to the FI, it had also disclosed additional costs it had not claimed previously. Because these additional costs, resulting from salary reclassifications, were outside the scope of our audit, we advised the Hospital to present these costs to the FI separately.

## **CONCLUSION**

For FY 1997, the Hospital submitted for reimbursement \$1,271,322 in charges for outpatient psychiatric services. Our audit of 100 randomly selected claims totaling \$38,440 disclosed that \$31,152 should not have been billed to the Medicare program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital billed at least \$750,790 in error for FY 1997. We attained our estimate by using a stratified variable sample appraisal program. The details of our sample appraisal can be found in APPENDIX A.

In support of the above claimed charges, the Hospital allocated to the Medicare program \$1.7 million in outpatient psychiatric costs, after reclassification and adjustments, on its FY 1997 Medicare cost report. We reviewed several judgmentally selected expense accounts related to nonsalary costs and found \$126,480 to be unallowable.

## **RECOMMENDATIONS**

We recommended that the Hospital:

1. Strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements.
2. Develop procedures to establish nonreimbursable cost centers or to otherwise exclude costs related to noncovered services from its Medicare cost reports.

We will provide the FI with details of the \$750,790 in estimated overpayments for outpatient psychiatric services and the \$126,480 in unallowable costs, so that it can apply the appropriate adjustment to the Hospital's FY 1997 Medicare cost report.

## **AUDITEE RESPONSE AND OIG COMMENTS**

The Hospital, in its February 22, 2000 response to our draft report (see APPENDIX B), acknowledged that it needs to improve its documentation standards and has taken steps to provide training to staff and to monitor compliance through various internal initiatives. We commend the Hospital for these actions. However, in regard to our finding of \$750,790 in estimated overpayments, the Hospital expressed general concerns regarding the criteria applied during the audit and stated that OIG unfairly applied the medical review standards of the new FI who was not under contract in Connecticut during the audit period. The Hospital also specifically disputed portions of this finding by stating that (1) PHP services denied for lack of physician certification were indeed proper, and (2) services denied for being recreational and diversionary in nature were appropriate for patient treatment.

In regard to our identification of \$126,480 in unallowable outpatient psychiatric costs, the Hospital was in agreement with \$88,850 of these costs as they were also identified in the Hospital's concurrent internal review. However, the Hospital disagreed with the remaining costs we found unallowable but stated that it was unable to provide validating documentation to support its contention.

In addition to the above response, the Hospital provided us, at the time of our exit conference, with a detailed, case-by-case, response to our findings. For reasons of patient confidentiality, we have not appended this detailed response to our report. However, we reviewed this information and provided it to the FI medical reviewers. The FI made no changes to its original determinations.

We believe that our final audit determinations are correct and no further adjustments to our report are necessary. We have summarized below the auditee's responses as they relate to our findings and have provided our additional comments.

### ***Auditee Response to Services Not Certified by a Physician***

The Hospital stated that, "...although the OIG was not satisfied with the Hospital's documentation of physician certification, the services did in fact meet HCFA standards for partial hospitalization and were necessary to prevent inpatient hospitalization. In fact, the medical records for many of the patients clearly indicate that the patients had been discharged from inpatient hospitalizations and placed in the partial program."

### ***OIG Comments***

In our review of the sampled PHP claims, we found no physician certifications in the patients' medical records that indicated that the patient would require inpatient psychiatric care if the PHP

services were not provided. The Act §1835(a)(2)(F), Medicare regulations at 42 CFR §424.24, and HCFA Program Memorandum, Publication 60A clearly require physician certification for patients entering a PHP and periodic re-certifications by the physician for continued need of care. The content of such requirements was transmitted to the Hospital by the FI via Medicare Bulletin H 95-54, dated July 19, 1995. In addition, we do not believe that placement into a PHP following inpatient hospitalization automatically qualifies a patient for a PHP level of care whereby the patient would revert to inpatient hospitalization if PHP services were not rendered. Moreover, medical record documentation for long-term PHP patients in our sample also did not contain the required physician re-certifications for continued treatment at that level of care. The determination that such services be denied remains unchanged.

### ***Auditee Response to Services Not Covered by the Medicare Program***

The Hospital stated in its response that services determined by the OIG to be “recreational and diversionary” and, therefore, not reimbursable by Medicare were correctly billed. The Hospital contends “...that Medicare should pay for these services...” as they were “...ordered by the patients’ physicians, included in individual treatment plans and related to specific goals for each patient...” Such services “...were carefully planned and supervised to meet specific goals relating to enhancing the patient’s ability to live and function safely outside an institutional setting.”

The Hospital stated that the services questioned were for patients in its RSP program. The RSP program “...is funded in part by the State of Connecticut, which initiated the program when it closed two long-term state psychiatric hospitals, one in close proximity to Danbury...” The Hospital further stated that “...several of the patients in the OIG sample once resided on a long-term basis in one of the closed state psychiatric hospitals. These patients are now trying to live successfully in the community and to continue to move toward a greater level of recovery.”

### ***OIG Comments***

Review of the patient medical records by FI medical reviewers and PRO psychiatrists showed that services to these patients were primarily psychosocial encounters not covered by Medicare. We recognize that the State of Connecticut (State) provided funding for the RSP Program. In the Hospital’s case-by-case detailed response given to us at our exit conference, the Hospital stated that, “Going hand-in-hand with this decision (to close the state psychiatric hospitals) was the creation of support programs to help ensure that these long-term psychiatric patients received the help they needed in their new independent living circumstances....” The Hospital RSP’s contract with the State required the Hospital to provide case management services addressing the patients’ “...clinical, medical, social, education, rehabilitative, vocational and/or other services essential to achieving optimal quality of life and community living....” We agree with the FI and PRO medical reviewers that these services are not covered under Medicare. We believe that such services relate to the goals and objectives of the Hospital’s grant contract with the State and are more appropriately funded under such. The determination that such services be denied remains unchanged.

### ***Auditee Response to Review of Outpatient Psychiatric Costs***

In regard to our identification of \$126,480 in unallowable outpatient psychiatric costs claimed on its FY 1997 cost report, the Hospital was in agreement with \$88,850 of these costs as they were also identified in the Hospital's concurrent internal review. However, the Hospital believed that OIG findings in excess of its self-disclosure, including certain advertising, travel, and meal expenses, represent appropriately billed Medicare costs even though it could not locate documentation to support its contention.

### ***OIG Comments***

Our determination that the identified costs are unallowable remains unchanged.

### ***Other Auditee Responses to our Draft Report***

**Retroactive Application of Empire Blue Cross Standards** - The Hospital believed that OIG was unfair in applying the policies and interpretations of the present FI, Empire Medicare Services, to our audit. During the FY 1997 audit period, Anthem Blue Cross/Blue Shield of Connecticut (Anthem) was the Hospital's FI. The Hospital stated that Anthem never issued local medical review policies addressing outpatient psychiatric services, including PHP services, nor could the Hospital obtain additional guidance from Anthem on reimbursement issues. Because of this, the Hospital relied upon HCFA guidance contained in statutes, regulations and program memoranda. The Hospital stated that this information was less specific than Empire's local medical review policies applied to the sampled claims. The Hospital noted the difference between Empire's policy requiring progress notes for each PHP therapy session and HCFA guidance suggesting that a daily PHP progress note is sufficient.

### ***OIG Comments***

We are aware that there was a change in FIs as described by the Hospital. However, Empire medical reviewers were instructed to evaluate the sampled claims in accordance with criteria applicable in Connecticut during the FY 1997 audit period. In addition to the above mentioned statutes, regulations, and program memoranda, Anthem sent out to all hospitals its Medicare Bulletins H 94-35, H 94-29, and H 95-54 during 1994 and 1995 providing guidance on outpatient psychiatric services, including PHP guidelines.

In reference to the Hospital's example citing the lack of guidance on progress notes for PHP services, our audit also disclosed that many of the PHP services denied because of the lack of physician certification also lacked progress notes for each therapy session billed. We maintain that individual progress notes are required and refer to 42 CFR §482.24 which states, "A medical record must be maintained for every individual evaluated or treated in the hospital...The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services." Our review of the Hospital's billing practices showed that the Hospital billed PHP services by individual therapy session, the daily charge amount dependent upon the number of sessions

attended. Therefore, we would expect individual therapy session notes to reflect the number of sessions attended. Moreover, in a similar audit of a Connecticut hospital from which we utilized Anthem medical reviewers, Anthem medical reviewers also applied its policy of individual progress notes.

## APPENDICES

REVIEW OF  
OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY THE  
DANBURY HOSPITAL

**SAMPLING METHODOLOGY**

Our population consisted of outpatient psychiatric claims with dates of service during the Hospital's FY 1997. Our stratified random sample consisted of two strata; claims with revenue center code (RCC) 513 (Stratum 1) and RCC 900-919 (Stratum 2).

	<u>Stratum 1</u>	<u>Stratum 2</u>
Population		
Items	4,193 Claims	723 Claims
Dollars	\$788,266	\$483,056
Sample (See Note)		
Items	60 Claims	40 Claims
Dollars	\$14,022	\$24,418
Errors		
Items	31 Claims	19 Claims
Dollars	\$10,798	\$20,354

PROJECTION OF SAMPLE RESULTS<sup>3</sup>  
Precision at the 90 Percent Confidence Level

Point Estimate: \$1,122,497  
Lower Limit: \$750,790  
Upper Limit: \$1,494,204

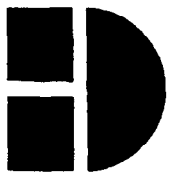
Note:

- All 60 sample claims in Stratum 1 were classified as other outpatient psychiatric services.
- There were 19 PHP claims and 21 other outpatient psychiatric service claims in the Stratum 2 sample.

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<sup>3</sup>

Based on our sample appraisal methodology, we are 90 percent confident that the dollar value of errors is between \$750,790 and \$1,494,204. Accordingly, we are 95 percent confident that the dollar value of errors is \$750,790 or more.



February 22, 2000

Mr. William Hornby  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203

Re: **Draft Report "Review of Outpatient Psychiatric Services Provided by the  
Danbury Hospital for Fiscal Year September 30, 1997"**  
**CIN A-01-99-00518**

Dear Mr. Hornby:

Danbury Hospital has reviewed the Office of Inspector General's ("OIG") draft report concerning the OIG's audit of outpatient psychiatric services provided by the Hospital during the 1997 fiscal year. As we understand it, the OIG has been conducting audits of outpatient psychiatric services at several hospitals in accordance with its annual workplan to determine whether hospitals are following Medicare requirements when they bill Medicare for outpatient psychiatric services.

In its draft report, the OIG finds that many Medicare charges submitted by Danbury Hospital's Partial Hospitalization and Outpatient Psychiatric Programs in 1997 did not meet certain Medicare requirements. However, for the most part the errors found involved specific technical documentation requirements for billing. The OIG does not conclude that the charged services were not actually provided to patients, or were not in fact valid partial hospitalization or outpatient psychiatric services. Nor does the OIG allege in general that these programs provided in 1997 were medically unnecessary. Indeed, Danbury Hospital's Partial Hospitalization and Outpatient Psychiatric Programs endeavors to provide clinically necessary services to the community we strive to serve.

As we discussed at the January 11th exit conference, Danbury Hospital has concerns about the standards applied during the audit and also disputes individual factual findings. At the exit conference, the Hospital submitted detailed narrative and additional documentation addressing certain claims that the OIG identified in its audit. This letter briefly reiterates the Hospital's primary concerns but does not discuss specific facts of individual cases. The Hospital

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understands that the OIG will refer its report and this response to HCFA and the Fiscal Intermediary. We further understand that you have already provided the Fiscal Intermediary with our detailed response and ask that it be included along with this letter in any submission to HCFA.

### **General Comments**

We have the following general comments and concerns about the OIG's findings:

#### **1. Retroactive Application of Empire Blue Cross Standards**

Danbury Hospital believes that the OIG unfairly applied Empire Blue Cross & Blue Shield ("Empire") policies and interpretations in conducting its audit of the Hospital. The OIG acknowledged that the Empire medical reviewers applied Empire's standards during their review of the Hospital's outpatient psychiatric claims. However, Empire was not the Hospital's Fiscal Intermediary during 1997, the time period covered by the audit. During 1997, the Fiscal Intermediary for Danbury Hospital was Anthem Blue Cross and Blue Shield. Anthem never issued local medical review policies for outpatient psychiatric services or partial hospitalization programs. Moreover, despite numerous attempts, the Hospital often could not obtain additional guidance from Anthem on reimbursement issues.

Because Anthem did not provide Danbury Hospital with specific information, the Hospital relied in good faith on HCFA guidance contained in the statutes, regulations and program memoranda. Such guidance was much less specific and detailed than Empire's local medical review policies. For example, Empire's local medical review policy requires progress notes for each therapy session held in a given day in a partial hospitalization program while HCFA guidance, which the Hospital relied upon, suggests that one daily progress note is sufficient. Empire's reviewers applied the standards in their local medical review policies to Danbury Hospital, despite the fact that Danbury Hospital was not subject to those policies until July 1, 1999, nearly two years after the time period subject to the audit.

#### **2. Partial Hospitalization Program Certifications**

In the draft report, the OIG finds that the 1997 partial hospitalization services reviewed were not reimbursable because patient medical records lacked express certifications stating that the services were necessary in order to prevent inpatient hospitalization or a continued inpatient stay. This technical documentation issue explains a large portion of the total overpayment cited in the draft report. We note that although the OIG was not satisfied with the Hospital's documentation of physician certification, the services did in fact meet HCFA standards for partial hospitalization and were necessary to prevent inpatient hospitalization. In fact, the

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medical records for many of the patients clearly indicate that the patients had been discharged from inpatient hospitalizations and placed in the partial program.

### **3. Responsive Services Program**

Danbury Hospital participates in the Responsive Services Program, an assertive community treatment model used to treat patients with serious and persistent mental illness. Patients participating in this program require psychiatric treatment aimed at stabilizing psychotic symptoms while supporting appropriate behavior in the community and avoiding inpatient hospitalizations. This is accomplished through frequent brief contacts at the clinic that monitor mental status, assure medication compliance, and intervene around psychosocial stressors that might lead to misbehaviors in the community or to lengthy and costly hospitalizations.

The program is funded in part by the State of Connecticut, which initiated the program when it closed two long-term state psychiatric hospitals, one in close proximity to Danbury. Many of the patients taking part in this service have histories of long stays, 2 to 25 years, in state psychiatric hospitals and/or histories in the criminal justice system. In fact, several of the patients in the OIG sample once resided on a long-term basis in one of the closed state psychiatric hospitals. These patients are now trying to live successfully in the community and to continue to move toward a greater level of recovery.

In the draft report, the OIG alleges that some of the services provided to Medicare patients by the Responsive Services Program in 1997 were "recreational and diversionary", and therefore not reimbursable by Medicare. The Hospital contends, however, that Medicare should pay for these services. The services at issue were ordered by the patients' physicians, included in individual treatment plans and related to specific goals for each patient. Although the activities involved, which included various social activities, may appear "recreational and diversionary," they in fact were carefully planned and supervised to meet specific goals relating to enhancing the patient's ability to live and function safely outside an institutional setting.

### **4. Cost Report Issues**

When the OIG commenced its audit, the Hospital conducted an internal audit of 1997 cost report items related to outpatient psychiatric services. As the draft report indicates, based on the results of the internal audit, the Hospital contacted the Fiscal Intermediary and voluntarily disclosed that it had identified significant costs that were likely to be disallowed by Medicare.

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The draft OIG report reaches similar conclusions on disallowed costs related to psychiatric services. The draft report identifies additional advertising costs as well as certain costs for travel and meals, which the OIG believes were not reimbursable by Medicare. Although the Hospital believes many of these costs were appropriately billed to Medicare, it could not locate documentation to verify them. In addition, the Hospital has discovered that it did not claim certain costs relating to psychiatric services on its cost report, which would have been reimbursable by Medicare. The Hospital believes that these costs should be offset against the OIG's projected cost report refund amount. The Hospital understands that the OIG cannot offset these amounts against the alleged overpayment for purposes of its audit findings, and therefore the Hospital will address this issue with the Fiscal Intermediary and HCFA.

#### **Remedial Action**

Although Danbury Hospital believes that all of the outpatient psychiatric services it has provided and continues to provide are necessary and appropriate, the Hospital recognizes the need to improve its documentation. In order to address the concerns raised by the OIG, the Hospital has taken several steps, which include:

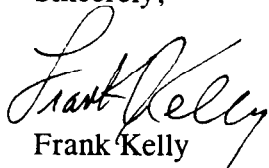
- 1) Conducting additional training and education of physicians and applicable Hospital staff on Medicare and Empire Blue Cross and Blue Shield documentation requirements for outpatient psychiatric and partial hospitalization services;
- 2) Performing an internal follow-up compliance review of outpatient psychiatric services regarding appropriate documentation; and
- 3) Identifying an individual in the Hospital who will have ongoing responsibility for working with the Corporate Compliance Officer to address psychiatric services compliance matters.

In addition, the Hospital will continue to monitor implementation of these corrective actions through the Danbury Health Systems Corporate Compliance Plan which strives to ensure that the Hospital complies with applicable state and federal laws.

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February 22, 2000  
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Thank you for allowing us the opportunity to comment on your draft report. We hope and trust that you will take the information provided above into account as you prepare your final report.

Sincerely,

A handwritten signature in cursive script, appearing to read "Frank Kelly".

Frank Kelly  
President, Danbury Hospital

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